

S. No. 2
M-8-43
5-17-39
I X37823

her. Primm 3332

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 8 1944
Registration District No. 361

Primary Registration District No. 6226

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jernson
(b) City or town Colo. Linnship
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution. 5 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Colman Ray Cullen
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex male **5. Color or race** w.
6. (b) Name of husband or wife.
6. (a) Single, widowed, married, divorced single
6. (c) Age of husband or wife if 0 years
7. Birth date of deceased. March 4, 1929
(Month) (Day) (Year)

8. AGE: Years 15 Months 6 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Humboldt, Kans.
(City, town, or county) (State or foreign country)

10. Usual occupation. Student

11. Industry or business.

MOTHER FATHER
12. Name. Chas. F. Cullen
13. Birthplace. Butler Co. Kans.
(City, town, or county) (State or foreign country)
14. Maiden name. Mary E. Wyatt
15. Birthplace. Humboldt, Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant. Chas. F. Cullen

(b) Address. Winfield R# 1, Mo.

17. (a) Burial. Winfield **(b) Date thereof.** 10-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Nevada B. Park

18. (a) Signature of funeral director. Bushinger Funeral Home

(b) Address. Nevada, Mo.

19. (a) 10-6-44 **(b) Mrs. W. L. Charles**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Vernon
(c) City or town Winfield Mo. R# 1.
(If outside city or town limits, write "RURAL")
(d) Street No. Winfield Mo. R# 1.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1
year 1944 hour 3 minute PM

21. I hereby certify that I attended the deceased from for 4 yrs
to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death. congenital heart disease
due to severe block
of dead when
called.
Duration from birth

Other conditions (Include pregnancy within 3 months of death)
Major findings: 1572
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at _____ (e) Means of injury _____

23. Signature N. B. Primm, M.D. (If D. or other)
Address Winfield, Mo. **Date signed** Oct-4-44

1225

(Licensed Embalmer's Statement on Reverse Side)

License No. 10-44-1236
Date Filed 11-7-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Mark Beehinger*
Licensed Embalmer No. *2656*
P. O. Address *Nevada, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.